



**MEDICAL INTAKE / PATIENT QUESTIONNAIRE**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Hand Dominance:  Right  Left Email address: \_\_\_\_\_

**TELL US ABOUT YOUR CURRENT CONDITION...**

Date of injury: \_\_\_\_\_ Date of surgery: \_\_\_\_\_

What happened? Briefly describe your current problem: \_\_\_\_\_

Please check all of your symptoms:  pain  stiffness  swelling  weakness  abnormal sensation  
 other: \_\_\_\_\_

Previous treatment for this problem? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Have you tried any braces and/or splints? \_\_\_\_\_

Please check any of the following activities that you are having difficulty with:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Eating / using utensils    | <input type="checkbox"/> Child care                   | <input type="checkbox"/> Home maintenance                |
| <input type="checkbox"/> Drinking                   | <input type="checkbox"/> Laundry                      | <input type="checkbox"/> Car repair                      |
| <input type="checkbox"/> Bathing / showering        | <input type="checkbox"/> Driving                      | <input type="checkbox"/> Hobbies - specify: _____        |
| <input type="checkbox"/> Dressing                   | <input type="checkbox"/> Using keys                   | <input type="checkbox"/> Work tasks - specify: _____     |
| <input type="checkbox"/> Grooming / toileting       | <input type="checkbox"/> Writing                      | <input type="checkbox"/> Playing sports - specify: _____ |
| <input type="checkbox"/> Cooking / meal preparation | <input type="checkbox"/> Keyboard / mouse use         | <input type="checkbox"/> Other: _____                    |
| <input type="checkbox"/> Opening jars and bottles   | <input type="checkbox"/> Texting / holding phone      | _____  |
| <input type="checkbox"/> Opening medication         | <input type="checkbox"/> Weight-bearing through wrist | _____  |
| <input type="checkbox"/> Lifting pots and pans      | <input type="checkbox"/> Going to the gym             | _____  |
| <input type="checkbox"/> Lifting bags of groceries  | <input type="checkbox"/> Gardening / yard work        | _____  |
| <input type="checkbox"/> House cleaning             | <input type="checkbox"/> Playing an instrument        | _____  |

**PAIN LEVELS**

On a scale of 0 – 10, circle the number that best describes the intensity of your worst pain in the last 2-3 days.  
0 = no pain to 10 = worst pain you could imagine.

0    1    2    3    4    5    6    7    8    9    10

**MARITAL STATUS**     Single     Married     Divorced     Widow     Separated

**WORK INFORMATION**

Are you currently employed?  Yes  No What is your job title? \_\_\_\_\_

What are your job duties / responsibilities? \_\_\_\_\_

What is your work status?  Full-duty     Full-time     Part-time     Restrictions     Retired  
 Light-duty     One-handed     Off-duty     Disability

**PLEASE CONTINUE ON THE OTHER SIDE**

## PAST MEDICAL HISTORY

Please check any past or current medical problems you may have:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fracture             | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> History of Cancer      |
| <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Obesity                |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Alzheimer's            | <input type="checkbox"/> Immunosuppression      |
| <input type="checkbox"/> Lupus                | <input type="checkbox"/> CVA                    | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Diabetes Type 1        |   |
| <input type="checkbox"/> Current Infection    | <input type="checkbox"/> Diabetes Type 2        |   |

Other (please list): \_\_\_\_\_

List any previous neck, shoulder, arm, and/or hand surgeries and/or injuries: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Are you a  non-smoker  smoker? Do you have any metal implants or a pacemaker?  Yes  No

Do you have any allergies? Please specify: \_\_\_\_\_

Are you taking any medications? Please list: \_\_\_\_\_

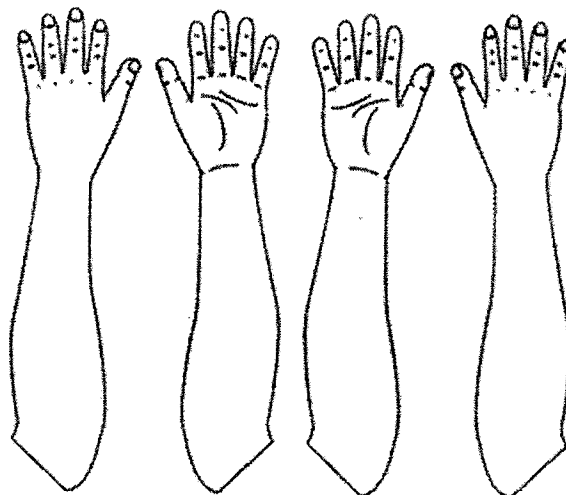
Have you had any of the following tests performed for your current problem?

### Test

X-rays	<input type="checkbox"/> Yes <input type="checkbox"/> No	CT Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nerve conduction test	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No
EMG	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## SYMPTOMS

Please use this diagram to circle any problem areas:



Left Arm

Right Arm

## GOALS

What are your goals in coming to therapy?  decrease pain  increase strength  improve motion  
 improve sensation  decrease swelling  return to work  improve dexterity  
 learn about joint protection & adaptive equipment  other goals: \_\_\_\_\_

**THANK YOU!**